EXHIBIT A - PART 2

004
20400414300
60021237

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient Elizabeth Horton Date(s) of Service Dec 06, Jan-Feb 07, March 07

Date of Birth 06-16-63 Social Security Number 430-37-8397

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☑ Legal Purposes
- ☐ Military
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability
- ☐ Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Lab/Pathology Reports
- ☐ Consultation Report
- ☐ Discharge/Death Summary
- ☐ X-ray Reports/Images
- ☐ Emergency Room Record
- ☐ Face Sheet
- ☐ Other: All Records

Springwood / Heb Hospital may release the above information to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):
(Hospital Name)

Attorney Deborah Dixon 334-213-1233
(Individual or Organization Name) Phone Number

3820 Fairlane Dr. Suite A10 Montgomery, AL 36116
Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date 9/25/07 Signature Elizabeth Horton
Patient or Legally Authorized Representative

Elizabeth Horton
Printed Name of Patient or Legally Authorized Representative

For Departmental Use: MRN/Acct# Relationship to Patient

Texas Health Resources

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Form 998540768 (Rev. 10/03)

Patient Identificati

9810

- ☐ AMH
- ☐ HCCH
- ☐ HMEC
- ☐ HMFW
- ☐ HMHEB
- ☐ HMNW
- ☑ HMSW
- ☑ HMSPG
- ☐ WRH
- ☐ PHA
- ☐ PHD
- ☐ PHK
- ☐ PHP
- ☐ PHW
- ☐ PVN
- ☐ Deuteronomy
- ☐ Other_____

FG 21157 (05/

MPS008 HARRIS METHODIST SPRINGWOOD 01/24/2007 08:49
1608 HOSPITAL PARKWAY, BEDFORD, TX 76022
Med Record No: 60021237

---------- P A T I E N T ----------

Patient Id No	Fin Class	Type Serv	Registration Date	Time	Admit Type	Admit Source	Admit Status	Downtime Number
204004143	003 USB	PO	01/24/2007	08:49		1	REC	

Infec Code	Confid Info	Smoke	Nurse Sta	Room No
	4		OSW	

Name,Maiden Name,Previous Name
HORTON,ELIZABETH,W,

Observation Date/Time

Marital Status
D

Address: 1713 ARBOR MILL 1415
City: BEDFORD State: TX Zip: 76021

Date Of Birth 19630618 Age 043
Sex: F Race: 2
Employer Phone (817)474-8245
Relationship: DAUGHTER

Phone: (817)685-1103 County:
Patient Employer:FIDELITY INVESTMENTS
Next Of Kin: BATTER,TANISHA,
Address:
City: MARIANNA State: AK Zip: 72360
Phone: (870)270-2588

---------- G U A R A N T O R ----------

Guaran Name: HORTON,ELIZABETH,W,
Relationship: PATIENT D.O.B.: 06/18/1963
Address: 1713 ARBOR MILL 1415
City: BEDFORD State: TX Zip: 76021
Phone: (817)685-1103
Guaran Occupation: CSR

Employer:FIDELITY INVESTMENTS
Address: 400 LAS COLINAS BLVD E Length Of Employ: 00 06
City: IRVING State: TX Zip: 75039-5579 Status: 1
Employee No: Employer Phone: (817)474-4000
LOS: 0 PRE-CERT:

---------- I N S U R A N C E ----------

Accident Type: Date: Time:

Carrier-Primary: UNITED BEHAVIORAL HEALTH
Address: 30755
City: SALT LAKE CITY State: UT Zip: 84130-0755
Policy Holder: HORTON,ELIZABETH,W,
Relationship: PATIENT Group Policy No: 119174
Cert/Medicare No/Insured Id No: 910619760 Eff Date: 01/01/2006
Phone: (800)888-2998 Employer: FIDELITY INVESTMENTS

Carrier-Secondary: BLUE CROSS BLUECHOICE PPO
Address: 660044
City: DALLAS State: TX Zip: 75266-0044
Policy Holder: HORTON,CHRISTOPHER,
Relationship: SPOUSE Group Policy No: 48584
Cert/Medicare No/Insured Id No: HYN817034883 Eff Date: 01/01/2006
Phone: (800)451-0287 Employer: HYUNADI

Religion: NO PREFERENCE Church: NONE

---------- D I A G N O S I S ----------

Chief Complaint/Diagnosis Case Type:
MDD
Attending Physician: TAJANI, HADI R

Previous Visit	Type	Arrival Transport	Referring Facility
01/03/2007	REC	PRIVATE CAR	

Patient's Bill of Rights: Voluntary Outpatients

When you apply for or receive mental health services in the State of Texas, you have many rights. Your most important rights are listed on these pages. These rights apply to all persons unless otherwise restricted by law or court order. A judge or lawyer will refer to the actual laws. If you want a copy of the laws these rights come from, you can call the Health Facility Licensure and Certification Division of the Texas Department of Health at 1-888-973-0022.

It is the responsibility of this hospital under law to make sure you have been informed of your rights. But just giving you this information does not mean your rights have been protected. This hospital is required to respect and provide for your rights in order to maintain licensure and do business in this state.

YOUR RIGHT TO KNOW YOUR RIGHTS

You have the right, under the rules by which this hospital is licensed, to be given a copy of these rights before you are admitted to the hospital as a patient. If you so desire a copy should also be given to the person of your choice. If a guardian has been appointed for you or you are under 18 years of age, a copy will also be given to your guardian, parent, or conservator.

You also have the right to have these rights explained to you aloud in simple terms in a way you can understand within 24 hours of being admitted to the hospital to receive services (e.g. in your language if you are not English-speaking, in sign language if you are hearing impaired, in Braille if you are visually impaired, or other appropriate methods).

YOUR RIGHT TO MAKE A COMPLAINT

You have the right to make a complaint and to be told how to contact people who can help you. Please speak first with your counselor or social worker. We'll try to resolve the issue right away. If we can't, we'll get back to you within 36 hours or two program days. You may also contact the agencies listed below.

You have the right to be told about Advocacy, Inc., when you first enter the hospital and when you leave. Information about how to contact Advocacy, Inc., is also listed below.

SPECIAL NOTE ON CONFIDENTIALITY

Your records are protected, except in special circumstances, including suspected abuse of a child or elderly or incapacitated person, or if you are viewed as an immediate danger to self or others. It may also be released in judicial proceedings, criminal proceedings, under court order or subpoena or in involuntary commitment proceedings.

Your medical record includes your physician's notes, and the notes of each member of the treatment team involved with your care. It will also be released if you sign a consent allowing it. You may wish to release only designated portions, such as the discharge summary.

If you believe any of your rights have been violated or you have been violated or you have other concerns about your care in this hospital you may contact one or more of the following:

Health Facility Licensure Texas Department of Health 1100 W. 49th St. Austin, Texas 78756	(TDD)	1-888-973-0022 1-800-735-2989 hearing/speech impaired
Advocacy, Incorporated 7800 Shoal Creek Blvd., Suite 171 E Austin,Texas78757		1-800-315-3876

STATEMENT THAT YOU HAVE RECEIVED THIS PAMPHLET/IT HAS BEEN EXPLAINED

I certify that:

___ I have received a copy of this document prior to admission.

___ Staff have explained its content to me in a language I understand.

Name: _____ Witness: _____

Date: 1/23/07 Date: _____

2004

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Basic Rights for All Patients

1. You have all the rights of a citizen of the State of Texas and the United States of America, including the right of *habeas corpus* (to ask a judge if it is legal for you to be kept in the hospital), property rights, guardianship rights, family rights, religious freedom, the right to register and vote, the right to sue and be sued, the right to sign contracts, and all the rights relating to licenses, permits, privileges, and benefits under the law.

2. You have the right to be presumed mentally competent unless a court has ruled otherwise.

3. You have the right to a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity.

4. You have the right to appropriate treatment in the least restrictive appropriate setting available. This is a setting that provides you with the highest likelihood for improvement and that is not more restrictive of your physical or social liberties than is necessary for the most effective treatment and for protection against any dangers which you might pose to yourself or others.

5.You have the right to be free from mistreatment, abuse, neglect, and exploitation.

6. You have the right to be told in advance of all estimated charges being made, the cost of services provided by the hospital, sources of the program's reimbursement, and any limitations on length of services known to the hospital. As part of this right, you should have access to a detailed bill of services, the name of an individual at the facility to contact for any billing questions, and information about billing arrangements and available options if insurance benefits are exhausted or denied.

7. You have the right to fair compensation for labor performed for the hospital in accordance with the Fair Labor Standards Act.

8. You have the right to be informed of those hospital rules and regulations concerning your conduct and course of treatment.

CONFIDENTIALITY

9. You have the right to review the information contained in your medical record. If your doctor says you shouldn't see a part of your record, you have the right at your expense to have another doctor of your choice review that decision. The doctor must also reconsider the decision to restrict your right on a regular basis. The right extends to your parent or conservator if you are a minor (unless you have admitted yourself to services) and to your legal guardian if you have been declared by a court to be legally incompetent.

10. You have the right to have our records kept private and to be told about the conditions under which information about you can be disclosed without your permission, as well as how you can prevent any such disclosures.

11. You have the right to be informed of the current and future use of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies, or photographs.

CONSENT

12. You have the right to refuse to take part in research without effecting your regular care.

13. You have the right to refuse any of the following:

- surgical procedures;
- electroconvulsive therapy (prohibited for minors under the age of 16);
- unusual medications;
- behavior therapy
- hazardous assessment procedures;
- audiovisual equipment; and
- other procedures for which your permission is required by law.

This right extends to your parent or conservator if you are a minor, or your legal guardian when applicable.

14. You have the right to withdraw your permission at any time in matters to which you have previously consented.

CARE AND TREATMENT

15. You have the right to a treatment plan for your stay in the hospital that is just for you. You have the right to take part in developing that plan, as well as the treatment plan for your care after you leave the hospital. *This right extends to your parent or conservator if you are a minor, or your legal guardian when applicable. You have the right to request that your parent/conservator or legal guardian take part in the development of the treatment plan. You have the right to request that any other person of your choosing, e.g., spouse, friend, relative, etc. take part in the development of the treatment plan. You have a right to expect that your request be reasonably considered and that you will be informed of the reasons for any denial of such a request. Staff must document in your medical record that the parent/guardian, conservator, or other person of your choice was contacted to participate.*

16. You have the right to be told about the care, procedures, and treatment you will be given; the risks, side effects, and benefits of all medications and treatment you will receive, including those that are unusual or experimental, the other treatments that are available, and what may happen if you refuse the treatment.

A:0087, Forms I
Revised:06/2000

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

[redacted] [redacted] [redacted] [redacted] [redacted]

ADMISSION ACKNOWLEDGEMENTS

Notice of privacy practices: I acknowledge receipt of the Texas Health Resources Notice of Privacy Practices. EJH *Initials*

Advance directives:

a. To be completed for Hospital outpatients and emergency room patients only:

Are you presenting an Out-of-Hospital DNR order or bracelet? ☐ Yes ☑ No Copy provided? ☐ Yes ☐ No

b. To be completed for Hospital inpatients and outpatients undergoing invasive procedures only:

1.	Who is answering the following questions? Patient?	☐ Yes	☐ No	Person with patient?	☐ Yes	☐ No
2.	Was printed information about advance directives offered to you?	☐ Yes	☐ No	Information received?	☐ Yes	☐ No
3.	Do you have a directive to physician (living will)?	☐ Yes	☑ No	Copy provided?	☐ Yes	☐ No
4.	Do you have a medical power of attorney?	☐ Yes	☑ No	Copy provided?	☐ Yes	☐ No
5.	Do you have a mental health directive?	☐ Yes	☑ No	Copy provided?	☐ Yes	☐ No
6.	Are you presenting an out-of-hospital DNR order or bracelet?	☐ Yes	☑ No	Copy provided?	☐ Yes	☐ No
7.	Would you like to discuss advance directives with a Hospital staff member?	☐ Yes*	☑ No	Referred to:		

I understand it is my responsibility to provide a copy of my advance directives to the Hospital.

(*Hospital Staff Note: Shaded area indicates that advance directive follow-up documentation is required.)

Patient rights and responsibilities: I have received written information regarding my rights and responsibilities as a patient. This information tells me how to register complaints I might have.

My valuables: I understand that the Hospital does not assume responsibility for personal property I may keep with me during my treatment / hospitalization. I understand that unnecessary items should be sent home, and that a safe is available for my valuables.

Financial agreement / assignment of benefits: I hereby irrevocably assign to the Hospital, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights (including causes of action and the right to enforce payment) under any insurance policies or any reimbursement or prepaid health care plan for services rendered during this admission. Under this assignment, Hospital shall have the right to appeal any denied or delayed claims on behalf of the insured or beneficiary. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment; I understand I am responsible for all health insurance co-payments and deductibles. Charity care may be available if Hospital eligibility criteria are met.

Release of information: I authorize the Hospital to release any information or records contained in hospital patient records related to alcohol or substance abuse diagnosis or treatment, mental health treatment, or any communicable disease, including HIV/AIDS to (a) any of my treating practitioners, (b) my insurance company or health plan, (c) any other person or entity that is responsible for paying or processing for payment my hospital bill, (d) any other health care provider to which I am transferred for care, (e) entities using this information for quality management and peer review, and (f) any other person or entity as authorized by law. This release shall remain valid until I notify the Hospital, in writing, of my desire to revoke it.

Physicians providing services: I understand that physicians, including my admitting physician as well as others, such as pathologists, radiologists, or anesthesiologists, who may provide diagnosis, care, or supervision of tests while I am in the hospital will bill me separately from the hospital, and that some or all of these may not be covered by the same health plans as the hospital, and that I will be responsible for paying these physicians, subject to the terms of whatever health plan or insurance I may have.

Medicaid patients only: I understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care. If I am a Medicaid Star patient, these provisions may not apply.

Medicare patients only: I acknowledge receipt of the written material entitled, "Important message from Medicare," which is located on the back of this form.

Obstetric patients only: This admission acknowledgement and financial agreement/assignment of benefits is also given for any child(ren) born to me during this hospitalization.

If the person signing this form is not the patient, please give full name, phone number and address:

I have read and understand the information above and on the back of this form.

Signature of patient or of the authorized representative* for an incapacitated patient	Relationship to patient	Date of signature
[signature]	pt	1/23/07
Witness	**Title**	**Date of signature**
[signature]	[signature]	1/23/07

*For purposes of this form only, an "authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child of the patient, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy.

HOSPITAL BOX MUST BE CHECKED

TEXAS HEALTH RESOURCES

ADMISSION ACKNOWLEDGEMENTS

FORM NO. THR-61 / 998540682 (5/04) PAGE 1 OF 2

9051

☐ AMH ☐ HMHEB ☐ WRH ☐ PHP
☐ HCCH ☐ HMNW ☐ PHA ☐ PHW
☐ HMEC ☐ HMSPG ☐ PHD ☐ PVN
☐ HMFW ☐ HMSW ☐ PHK ☐ Other

MEDICAL RECORDS

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 DSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan ("your Plan") if you are a Plan enrollee.
- You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
- Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.

YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

Date of Discharge: When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.

Your Right to an Immediate Appeal without Financial Risk: When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800 MEDICARE (1-800-633-4227), or TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a noncoverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you.
The QIO will decide within one day after it receives the necessary information.

Other Appeal Rights: If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone number of the QIO (or of your Plan).

UNIVERSAL CONSENT FOR TREATMENT

General consent. I understand that my health condition requires inpatient or outpatient admission. I consent to and authorize testing, treatment and hospital care by Hospital nurses, employees, and others as ordered by my doctor and his/her consultants, associates, and assistants, or as directed pursuant to standing medical orders or protocols. I understand that it may be necessary for representatives of outside health care companies to assist in my care. I also understand that persons in professional training programs may be among the individuals who provide care to me. I understand that in connection with my treatment, photos or videos may be taken. Any tissue or body parts removed from my body may be retained or disposed of by the Hospital at its sole discretion.

Communicable disease testing. I acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, the Hospital may perform tests, without my consent, on my blood or other bodily fluid to determine the presence of hepatitis B and C and HIV. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at the Hospital. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my hospital patient record.

Independent physicians. I acknowledge that the doctors taking part in my care do not work for the Hospital. They are engaged in the private practice of medicine, and are not employees, servants or agents of the Hospital. In addition to my attending doctor, other doctors who may take part in my care may include radiologists, pathologists, anesthesiologists, neonatologists, cardiologists, emergency physicians and other specialists. I acknowledge that the Hospital is not responsible for the judgment or conduct of doctors who treat or provide a professional service to me. The exception to this is that some medical residents -- doctors taking part in a program of post-graduate medical education under the supervision of more experienced physicians -- are employees of the Hospital.

No guarantee. I acknowledge that no guarantees or warranties have been made to me with respect to treatment to be provided at this Hospital. I understand that all supplies, medical devices and other goods sold or furnished to me by the Hospital are sold or furnished by the Hospital on an "AS IS" basis, and Texas Health Resources disclaims any expressed or implied warranties with respect to them. With respect to specific supplies and devices, manufacturers' warranties may apply, and I may request manufacturer's warranty information concerning such supplies and/or devices.

Newborn child(ren). If any children are born to me during this admission, my signature below is on behalf of myself and such child(ren) as the legally authorized representative of such child(ren), and the paragraphs regarding "General consent", "Communicable disease testing", "Independent physicians" and "No guarantee" shall apply regarding any treatment provided to such child(ren).

If the person signing this form is not the patient, please give full name, phone number and address:

I have read and understand this information.

Signature of patient or legally authorized representative*	Relationship to patient	Reason patient unable to sign
Witness	Title	Date of Signature 1/23/07

*For purposes of this form only, a "legally authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy.

HOSPITAL BOX MUST BE CHECKED

TEXAS HEALTH RESOURCES

UNIVERSAL CONSENT FOR TREATMENT

THR-60 / 998541055 (5/04)

9080

☐ AMH ☐ HMHEB ☐ WRH ☐ PHP
☐ HCCH ☐ HMNW ☐ PHA ☐ PHW
☐ HMEC ☐ HMSPG ☐ PHD ☐ PVN
☐ HMFW ☐ HMSW ☐ PHK ☐ Other_____

ENTI[illegible] CATION

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSN
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH CARE INFORMATION

1."DIRECTORY INFORMATION." I understand that "Directory Information", such as my presence in the hospital and room number, as described in the Texas Health Resources Notice of Privacy Practices, may be released to all who ask for me by name, unless I object by specifically requesting to be a "No Information" patient as described below.

☐ **No Information** - I do not authorize release of any information, including Directory Information, concerning my admission or treatment. I choose to be a "No Information" patient and I realize that mail, flowers,telephone calls, and visitors will be refused on my behalf. (The hospital staff will not be able to acknowledge my presence.) I also understand that if I make phone calls from the hospital, caller identification systems may result in my location being disclosed to persons who receive the calls.

2. MEDICAL INFORMATION AND DISCLOSURE. I understand that medical information about my condition and treatment, may not be released, except in situations as described in the Texas Health Resources Notice of Privacy Practices, **unless I give my permission as provided below:**

☐ **I authorize** this hospital and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.

☐ spouse_____

☐ children _____

☐ parent(s) _____

☐ other _____

Note:I understand my medical information will not be discussed via telephone with the person(s) named above if I choose to be No Information since telephone calls will be refused on my behalf.

This authorization will expire at the end of my hospitalization or outpatient service, unless I revoke the consent prior to that time.

Signature of Patient or Legally Authorized Representative* — Relationship: Self — Date: 1/23/07

Witness — Date: 1/23/07

*A"legally authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy.

HOSPITAL BOX MUST BE CHECKED

9100

TEXAS HEALTH RESOURCES

Authorization for Verbal Release of Protected Health Care Information

Form 998540228 (Rev. 7/05)

☐ AMH ☐ HMHEB ☐ WRH ☐ PHP
☐ HCCH ☐ HMNW ☐ PHA ☐ PHW
☐ HMEC ☑ HMSPG ☐ PHD ☐ HMFW
☐ HMSW ☐ PHK ☐ Other_____

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

FQ 21892 (06/05)

I hereby agree to the performance of an interview and the collection of data deemed necessary on the below named client by Harris Methodist Springwood. I understand that the Harris Methodist Springwood employee will be consulting with a physician regarding any recommendations for care. I also understand that Springwood is not the emergency room, but that Harris Methodist HEB has an ER available if I believe I have an emergency medical condition. The hospital will provide screening and stabilization for an emergency medical condition regardless of ability to pay.

Physicians are not employees of the hospital. If I see a physician, the physician will bill me, including for any visit associated with this session.

Patient Rights: My record is confidential unless I choose to release it, except in very specific circumstances, including, but not limited to, any account of harm to a child or elderly person or any account of imminent danger to self or others. If I am admitted to additional care, I'll receive an additional statement of patient rights.

I may ask to see the Business Office Staff to answer questions about any financial obligation that might apply.

Elizabeth Horton
Client's Name (Please Print)

Elizabeth Horton
Client's Signature

1-23-07
Date

Others Accompanying Client: _____

_____
Parent/Legal Guardian Signature

HARRIS METHODIST SPRINGWOOD

CONSENT FOR EVALUATION
HMSP-043 (Revised 12/06)

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

9300

This document details many of the specific requirements of attending the psychiatry outpatient programs. My signature indicates that I've read it, have spoken with a staff member and/or my attending physician about any questions that I have about it, and agree to all points.

CARE PLAN:

I agree to work with staff, so that I understand the recommended treatment plan. The overall goal is that I improve in mood and/or functioning so that I no longer need a hospital program.

SAFETY:

I understand that safety is always primary, so I'll abide by the hospital rules prohibiting any weapons, drugs or excess medications.

SAFETY AFTER HOURS:

I agree to let the staff or my physician know right away if I'm feeling that the program is not effective for me, or if I believe that I'm in an emergency, including any thoughts or intent to harm self or others. After hours or on weekends, the physician is my contact for any emergencies.

ATTENDANCE:

I agree to attend all groups recommended by my physician, to be on time, not to leave group early, unless there is an emergency and I've spoken with my primary clinician about it. Failure to comply with attendance will be considered a request to discharge. If I'm absent or don't attend all groups for two days or more, my physician may discharge me.

GROUP WORK:

I understand that the treatment approach at Springwood is group-based, and is focused on finding solutions to the immediate, real-life problems that I face.

COORDINATED CARE:

I agree to notify the doctor if I'm seeking medical treatment and what that care consists of while I'm in treatment, including any medications prescribed by other physicians.

MEDICATION:

I agree to take my medication as ordered and to discard any medication at home that is not currently ordered. I agree to be thorough in listing all medications ordered by other physicians now or added during treatment so that the attending physician may review this for any possible interactions.

NO CLOSE RELATIONSHIPS WITH PATIENTS:

I agree to avoid "close relationships" or physical/romantic intimacy with other patients. Intimate involvement will distract me from my recovery and could lead to early discharge.

Patient Signature/Date

9300

Harris Methodist Springwood

Outpatient Agreement

FORM HMSP-028 (REV. 2/01)

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

[redacted] [redacted] [redacted] [redacted] [redacted]

CONSENTS AND RELEASES

SERVICE TO FAMILIES

Springwood believes families of our patients are a very important part of treatment. For this reason, we provide a variety of services to families. The patient schedule lists family groups, which are available at several different times during the week.

The hospital staff and/or my physician have my permission to contact my family or significant other as named below to obtain a Social History, if my physician requests, for orientation to program services, to notify them if seclusion or restraint is initiated, and to assist in coordination of discharge plans, including disposition of any safety issues at home.

Individual family sessions with the Social Worker can also be arranged by consulting your physician.

In addition to the persons I have named as emergency contact, this release includes:

Name of family member(s) / Telephone

Other contact person / Telephone

GENERAL RECREATIONAL ACTIVITY

I, the undersigned, wish to participate in and pursue general recreation activities, as allowed, while I am in treatment at Harris Methodist Springwood. I hereby represent that I am participating in these recreational activities voluntarily and of my own volition, and further that I am under no pressure to participate therein.

Therefore, I and/or my parent/managing conservator/guardian hereby willingly and consciously waive and release Harris Methodist Springwood, its employees, officers and agents, and physicians associated with Harris Methodist Springwood and any other patients in the Harris Methodist Springwood program from and against any and all claims, costs, liabilities, judgements or expenses, including attorneys fees and court cost arising out of or precipitated by my participation in recreational activities while I am in treatment at Harris Methodist Springwood. I also release and agree to hold harmless Harris Methodist Springwood, its employee, officers and agents, and associated physicians, and any other patients participating in recreational activities from untoward results of any illness or injury resulting from my participation in such recreational activities. Furthermore, I hereby agree to indemnify and hold harmless Harris Methodist Springwood, its employees, officers and agents, and associated physicians against any and all claims except those resulting from gross negligence or willful misconduct thereby, that may arise from such recreational activities.

CONSENT TO PHOTOGRAPH, CAMERA AND AUDIO

I, the undersigned, consent for Harris Methodist Springwood to photograph me for the purpose of identification only. I further understand that the photographs are not to be released, except with my consent or pursuant to law. Photographs are the property of Harris Methodist Springwood and are destroyed at the time of patient discharge. Further, Springwood staff may monitor me by camera and/or audio equipment for safety purposes.

REFERRALS TO OUTSIDE AGENCIES/PROVIDERS

Texas Health Resources and its affiliates, including Springwood, do not endorse or monitor these resources nor do they guarantee the quality of services provided by the resources.

PERSONAL BELONGINGS AND MEDICATION FROM HOME

I understand that the hospital is not responsible for my belongings. If I leave anything, including medication, at the hospital after discharge, I understand it will be destroyed within 24 hours.

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by Harris Methodist Springwood is mandated by Federal laws and regulations. Generally, the program may not say to a person outside Harris Methodist Springwood that a patient attends Harris Methodist Springwood, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1) The patient consents; or
2) The disclosure is pursuant to a court order; or
3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violation may be reported to appropriate authorities in accordance with Federal regulations. Federal laws and regulations do provide a number of disclosure exceptions. For example, federal laws and regulations contain an exception which does not protect any information about a crime committed by a patient either at Harris Methodist Springwood or against any person who worked for Harris Methodist Springwood or about any threat to commit such a crime. Federal laws and regulations also contain an exception which does not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 and 42 CFR Part 2 for statutory/regulatory.)

Please also be aware that you will encounter visitors, other patients and their guests while you are here, especially in the lobby, corridors, cafeteria and other parts of the hospital.

SMOKING WAIVER

Harris Methodist H.E.B./Springwood is a designated smoke-free hospital. Smoking has been determined, by the Surgeon General, to be hazardous to health. I am aware of the risks and hazards of smoking and assume sole responsibility for those risks and hazards to my health. I understand that my doctor can advise me about smoking cessation. Also, I am aware of smoking cessation classes and/or programs, including American Lung Association: 817-732-6336 and American Cancer Society: 817-737-3185.

INFECTIOUS DISEASES

The Centers for Disease Control have listed risk factors for transmission of hepatitis C. Hepatitis C is a virus that can cause chronic diseases of the liver, including scarring (cirrhosis) and liver cancer, both of which can result in death. These risk factors may also apply to AIDS/HIV and other contagious diseases. I understand that if any of these factors applies to me, I need to see my primary care doctor and/or a public clinic for testing and follow-up. Two of the high-risk factors are injection of illegal drugs even one time and exposure to other person's blood including by sexual contact. My doctor can advise me about other factors. Springwood does not provide diagnostic testing except as part of medical emergencies that arise during psychiatric or addiction treatment, and is not responsible for testing me. I understand and will follow up outpatient if I'm concerned and if any of the risk factors apply to me.

THIS IS A LEGAL CONSENT AND RELEASE OF LIABILITY FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

1/23/07	Elizabeth	HORTON,ELIZABETH,W, 204004143 003 MR# 60021237 OSW DR. TAJANI,HADI R 01/24/07 USB F 043 DOB 06/18/63
DATE	PATIENT/MANAGING CONSERVATO	
1/23/07		
DATE	WITNESS	

THIS SECTION FOR STAFF AND PHYSICIAN ONLY

I. **TREATMENT RECOMMENDATIONS/CONCERNS:**

(Y)/N Care plan, diagnosis, and health screen information agree? If not, contact physician to clarify.
N/A Y/N If dual diagnosis is indicated, is CD track ordered?
N/A Y/N If dual diagnosis, are drug screens ordered?
(Y)N Safety issues at home are resolved? If not, notify physician.
(Y)N Mental Status exam complete (or copy from inpatient) and on the chart? If not, contact physician.
Y(N) Is screen for pain positive? If so, complete pain assessment.
(Y)N Are medical/biophysical needs included on treatment plan?

Staff signature/date: Marilyn Pettway LPN 1-31-07

II. **ADMITTING PHYSICIAN RECOMMENDATION:**

_____ No further investigation/referral indicated
_____ Requires further investigation/referral, specify: _____
_____ ROI needed to confirm resolution of safety issues at home.
_____ Patient needs higher level of care. See orders.

Reviewed by: _____ Date: 1-31-07
(Signature of Admitting Physician)

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Medication allergies? NO Type of reaction? _____
Latex allergies? NO Type of reaction? _____
Food allergies? NO Type of reaction? _____

PATIENT'S CURRENT MEDICATIONS:

MEDICATION	DOSAGE	PRESCRIBING DR.	HOW LONG ON MED?
[illegible]	375	Dr Jagna	November 2006
Lunesta	3mg	Dr Tijani	11/2006
Ambien	300/10	Dr Looney	1/2007
Lotrel	10	Dr Looney	1/2007

Please contact your doctor or nurse if you have any questions about your medication or food-drug interaction.

Please list any current medical conditions you have or are currently under treatment for:

CONDITION	TREATING PHYSICIAN	LAST VISIT WITH PHYSICIAN
Depression	Dr. Tijani	1/23/06
Blood Pressure	Dr. Looney	1/18/06

Date of last physical? 1/2006 Results: normal
Are your immunizations up to date? Yes / No
Are you currently in pain, or have you had pain in the recent past? Yes/No
Do you smoke tobacco? No Brand? _____ Number of cigarettes per day: _____
Do you chew tobacco? No Brand? _____ Amount per day? _____
Do you have any physical disabilities we should consider? No
Do you have any barriers to learning we should consider? No
What is your spiritual preference? NP
Are there any cultural or spiritual conflicts that will impact your treatment? NO

Please remember that you can call the business office at 355-7708 to discuss your insurance coverage and financial arrangements of your care.

Elizabeth Horton
Patient's signature

1/24/07
Date

HARRIS METHODIST SPRINGWOOD
OUTPATIENT HEALTH SCREEN
Page 3 of 4
9/06

9300

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

WOMEN ONLY:
Menstrual problems? no
Date of last pap smear? 1/2006
Are you pregnant? no
Are you breastfeeding? no

PERSONAL HEALTH HISTORY: Please indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Measles	✓		Hepatitis		✓	Lung Disease		✓
German Measles	✓		Liver Problems		✓	Asthma		✓
Chicken Pox	✓		Pancreatitis		✓	Arthritis, MS		✓
Chicken Pox	✓		Typhoid		✓	Stroke		✓
Polio		✓	Tuberculosis		✓	Cancer	✓	
Rheumatic Fever		✓	Positive TB Test		✓	Ulcers		✓
Scarlet Fever		✓	Lymes Disease		✓	Head/Brain Injury		✓
Mumps	✓		Heart Disease		✓	HIV/AIDS		✓
Diabetes		✓	Kidney Problems		✓	Autoimmune Diseases		✓
Thyroid/Endocrine Problems		✓	Gallbladder Problems		✓	Sexually Transmitted Disease		✓

FAMILY HEALTH HISTORY: Please indicate if anyone in your family has had the following illnesses.

	Yes	No	Family Member
Cancer	✓		father lung
Diabetes	✓		Mother
Tuberculosis		✓	
Lung Disease		✓	
Heart Disease	✓		mother
Kidney/Renal Disease		✓	
Autoimmune Disease (Lupus, MS, RA)		✓	
Stroke	✓		Mother
Dementia/Alzheimer's		✓	

HORTON,ELIZABETH,W,
204004143 D03 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

OUTPATIENT HEALTH SCREEN

If you are being admitted directly to IOP, please complete the questions on this form and sign where designated.

If you are being admitted to IOP after being discharged from the Inpatient Unit or the PHP, please note any changes since your Inpatient or PHP stay in any of these areas and then sign. If there have been no changes, please check the "NO CHANGES" box just above the signature line on page 3.

CURRENT HEALTH INFORMATION:

Symptom	Now	Recent Past	Symptom	Now	Recent Past
Chest pain		✓	Problems urinating		
Shortness of breath		✓	Unusual discharge		
Palpitations			Diarrhea		
High blood pressure		✓	Abdominal pain/cramping	✓	
Ankle swelling			Constipation		
Easily bruised			Recent weight gain or loss/amount__	✓	
Persistent cough	✓	✓	Nausea/vomiting		
Night sweats			Induced vomiting		
Frequesnt or severe headaches	✓		Frequent use of laxatives		
Dizziness	✓		Frequent indigestion		
Problems sleeping	✓		Loss of appetite	✓	
Weakness/fatigue	✓		Problems swallowing		
Coordination problems	✓		Sores that won't heal		
Numbness	✓		Rash		
Muscle cramp/twitch			Frequent earaches		
Tremors/hands shaking			Frequent colds		
Bloody urination			Men: Prostate problems		

HARRIS METHODIST SPRINGWOOD
OUTPATIENT HEALTH SCREEN
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9300

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Individual Elizabeth Horton Date: 1-23-07

I, _____, have been advised of the hospital's obligation to provide a medical screening examination to detect whether I have an emergency medical condition. That is, it has been explained to me and I understand that I can go to the Emergency Department if I believe that I have an emergency medical condition and desire a medical screening examination. I understand an emergency medical screening examination is available to me without regard to my method of payment or my ability to pay. I am not asking for such an examination.

I, _____, agree that if I begin to feel suicidal or have thoughts of harming anyone else after leaving the hospital, I will seek help rather than harm myself or someone else. I know that I can receive help through the resources listed on the information given to me today, including returning to this hospital.

Elizabeth Horton 1-23-07

Signature of individual Date

If individual declines to sign, staff member explains the situation.

_____

_____

_____

_____ _____

Person completing form Date

9300

Harris Methodist Springwood

CONSENT TO LEAVE WITHOUT SEEING A PHYSIC

HMSP-010 (Rev. 10/00)

PATIENT IDENTIFICAT

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

LEVEL OF CARE:

____ Psychiatric Partial Hospital Program
____ Psychiatric Intensive Outpatient Program

DISCHARGE DIAGNOSIS:

Axis I MDD
Axis II —
Axis III —
Axis IV ✓
Axis V 55

Date of Discharge: 2-14-2007

THE PATIENT'S TREATMENT COURSE INCLUDED:

✓ Medical Management including medication stabilization
____ Nursing Management
✓ Group Therapy (Group therapy addressed behavioral and cognitive changes to improve coping with stress and symptomology, and included Goal Setting, Anger Management, Assertive Communication, Self Care, Medication Education, Balancing Life Roles, Stress Management, Family Education, and Process Groups
____ Family/Significant other participated in treatment
____ Family/Significant other did not participate in treatment

PATIENTS RESPONSE TO TREATMENT:

✓ Increased insight
✓ Improved mood
✓ Decreased anxiety
✓ Stabilization/Remission of Suicidal Ideation/Intent
✓ Increased coping
✓ Improved cognition
____ Stabilization/Remission of Danger toward others
____ Increased energy
____ Other
✓ Patient completed recommended programming
____ Patient did not complete recommended programming and was discharged AMA (Against Medical Advice)
____ Patient was unable to benefit from continued treatment at this level of care and was therapeutically discharged

DISCHARGE RECOMMENDATIONS:

✓ Continue medication regime as prescribed by attending psychiatrist
✓ Follow-up appointment with attending psychiatrist on Dr. Tajani 2-20-07 at 2:15
____ Follow-up appointment with Primary Care Physician and/or Specialist for ____
✓ Follow-up appointment with outpatient psychotherapist Cheryl Bowie 2-15-07 at 8:00
____ Patient admitted to higher level of psychiatric care
____ Inpatient Psychiatric Care at Harris Methodist Springwood
____ Patient transitioned to lower level of psychiatric care
____ IOP at Harris Methodist Springwood
✓ Other Discharge Recommendations Pt. to maintain community resource info

Electronically signed by HADI TAJANI, MD on 03-05-2007

Attending Physician: Dr. H. Tajani Signature: ____ Date: 2-14-07

Clinician: M. Potthoff LCSW Signature: M Potthoff LCSW Date: 2-14-07

Harris Methodist Springwood
PSYCHIATRIC TREATMENT DISCHARGE SUMMARY

2016

PATIENT IDENTIFICATION
HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

1. Teaching Description Family/Patient:	Patient Verbalizes Understanding			Family Verbalizes Understanding		
	Yes	No	N/A	Yes	No	N/A
Eliminate access to weapons/stash of meds						
Adequate rest, nutrition, exercise						
2. Patient Instructions to include effects, side effects & any food to drug or drug to drug interactions.						
Ask your pharmacist or doctor about this medication, including storage or what to do about a missed dose, and any other further questions.						
Discharge Medications Prescribed:						

3. Patient verbalizes understanding of necessity for medication compliance post discharge.	Yes	No	N/A
4. Referrals as Ordered. Discussed:	(Yes)	No	N/A
a. Outpatient Program:			
b. Outpatient follow up with attending physician: Dr. Tajani (c Susan) 2-20-07 at 2:15 PM			
c. (Individual)/ Family therapy with: Cheryl Bowie 817-545-8875 2-15-07 at 8:00 AM		✓	
d. Support Group: Depression 817 335-5405	✓		
e. Other Services:			
f. Chemical Dependency Aftercare attendance _____ times per week			
g. NA/AA attendance _____ times per week			
h. Home group/sponsor identified			
i. PCP and/or other physician:			
j. For Pain Management / Medication Management, Other:			
5. Patient verbalizes understanding of discharge instructions and willingness and ability to comply.	✓		
6. Patient verbalizes knowledge of community crisis resources available if needed discharge.	✓		

I have rcvd and understand instructions as noted above. I have all my belongings and valuables.

Signature of patient/Responsible Person — Date: 2-14-07

Other Discipline (if applicable) M Patthoff, LCSW — Date: ~~1-24-07~~ 2-16-07

Other Discipline (if applicable) — Date:

Signature of Registered Nurse (if applicable) Susanita Jakarsa — Date: 2-14-07

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/16/63

Harris Methodist Springwood

BEHAVIORAL HEALTH DISCHARGE SUMMARY

FORM 998540743 (REV. 6/02)

2016

	Yes	No
Suicidal ideation expressed		
Delusional ideation expressed		
Hallucinations identified		
Explanations of "Yes" items:		
Oriented/Alert		
Speech rate WNL		
Speech organized		
Nutritional Status WNL		
Explanation of "No" item:		
Patient's perception of discharge:		

Staff Signature Date

Patient Discharge:
Time _____ Date _____

CHECK ALL APPLICABLE:
Ambulatory _____ Wheelchair _____

Ambulance Stretcher _____
Service _____
To: Home _____ AMA _____ Nursing Home _____
Order for Protective Custody _____
Other _____
Unaccompanied _____
Accompanied by _____

CHECK ALL APPLICABLE:
Discharge Biophysical Nursing Assessment:
Speech impaired _____ Vision impaired _____
Hearing impaired _____ Mobility impaired _____
Difficulty in bathing self _____
Difficulty in dressing self _____
Difficulty in feeding self _____
Dressing or bandages in place _____
Appliances or supports _____
Explanation of items checked above: _____

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

IOP GOALS AND OBJECTIVES:
MOOD DISORDER/ALTERATION IN MOOD:
Long Term Goal: Identification of next steps in treatment Community reintegration Make next appointments
Short Term Goals: Stabilize mood Complete necessary assessment Family involvement Program participation
Treatment Plan assessed weekly and when changes occur

Patient objectives established at admit: 1-24-07	First Review	Progress Review	Progress Review	Outcome Review	Responsible Staff	Intervention(s)
Stabilize mood within 15 days. Axis I: MDD (Had SI passive on Sat) Denies currently.	Symptoms of: Ø SI, Anxiety attacks, Disturbed sleep, Panic, No appetite, Hopeless	Poor focus, Poor memory, - hasn't eaten in	1-31, Passive SI, Irritable, Hopeless, 4 day	Ø SI, Thoughtfulness, Stable sleep, ↑ appetite, Reduced anxiety	Counselor RT [signature] LCSW	RT/Goal Setting & primary counselor to assess and increase behavioral/functioning changes in self care & responsibilities.
Complete all assessments within 3 program days.	Health Screen, H & P copy	Mental Status, PSY eval	Social HX		MD/DO Counselor	Social Hx, PSY eval/Mental Status, Educational Assessment Health Screen. Identify needs.
Participate in groups to address stressors of: Stress at work facing mgr. Passed over since [illegible] to finish her last Nov.	Crisis Plan, Balance, ⊕ Coping Skills, Cognitive Change	Affirmation			Counselor; RN RT; Chaplain [initials]	Group Therapy to address coping with specific issues and increase problem solving, life skills, stress management, social interaction, and self care.
Comply with med. & lab. Understand med education. Report response to meds. Report allergies: None known	List Meds: Effexor 37.5 mg 2 per day, Lunesta 3 mg 1 at night, Alvide 300/10 1x daily, Lotrel 10 mg 1x daily.				MD/DO; Counselor [initials]	Med Education Group to explain meds, purpose, side effects and alternatives. Physician to provide assessment & education.
Participate in family group minimum of 2 time(s).	Supportive family member:	- Works at Fidelity Investments last 6 mths. Customer Service			Counselor	Educate patient and family on family role and encourage family participation in multi-family group.
Finalize Discharge including resolution of any safety issues.	Safety Issues: Y (N) Resolution:	- Lives alone 3 children grown & live in area			Counselor OTR	Plan for follow up w/ medication, therapy community resources, and support groups.
Identify specialized bio-physical/cultural/educational/ psychosocial needs:	Pt given info on diagnosis	- Was divorced June 06 - Mother also died June 06 - Survivor of breast cancer			Identified Staff	Assess, monitor, and refer for pain management/ physical issues, as needed; Specialized groups as ordered; Refer for community resources as needed. Educate and/or refer as indicated.
Participate in TX plan changes or crisis management planning:	Crisis plan, Weekend plan, Contracting	- Last June dx c high blood pressure			Identified Staff [initials]	Facilitate planning for crisis or relapse and address changes in status as needed.

1-31-07
Effexor XR 225 mg day

2005

TREATMENT PLAN

HORTON, ELIZABETH, W,
204004143 003 MR# 60021237 OSW
DR. TAJANI, HADI R
01/24/07 USB F 043 DOB 06/18/63

Discharge Plans Reviewed:

___ Psychiatrist ___   ___ RTC ___

✓ Individual/Family Vallotte Liedtke Hendrickson   ___ AA/NA

___ Support Groups: ___   ___ Other resources ___

✓ PCP or other physician ___

Clinical issues not addressed in this hospitalization: ___   **Rationale:** ___   **Referrals/Resources** ___

Estimated date of discharge: 2-14-07

Comments: ___

Signatures:	Review Date	Review Date	Review Date	Review Date	Review Date
Patient: I agree to follow the treatment program. [illegible]	2-1-07	2-8-07			
Physician: [illegible] (Signature indicates confirmation of medical necessity for treatment.)	[illegible]				
Primary Counselor: Marilyn Pettkoff, LCSW	MP	MP			
Staff: Gary S. Kizzo MSW [illegible] LCSW Jay Stanko RN [illegible] OTR	[illegible] [illegible] [illegible] [illegible]	[illegible] [illegible] [illegible]			

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

MRN: 60021237HEB Visit: 204004143003 Doc Type: 2021 CONFIDENTIAL INFORMATION

DATE	HOUR	EACH NOTE MUST BE IDENTIFIED BY DISCIPLINE NAME AND SIGNED BY LICENSED STAFF
1-26-06	1450	Pt. absent today. Called in to say that
		she has pink eye. M Patthoff, LCSW
1-29-06	1400	Pt. absent today. Placed call, → no answer
		Requested return call M Patthoff, LCSW
1/31/07	.	[illegible] Conjunctivitis
		Mood as [illegible]
		Sleeping [illegible]
		[illegible]
		↑ Effexor to 225,
		[illegible signature]
1-31-07	1500	Per pt. request, placed call to her
		disability co Hartford. Said they needed
		doctor to fill out forms. Jennifer will
		fax forms. M Patthoff, LCSW
2-5-07	1630	Pt. absent today. Placed call but no
		answer. Requested return call. M Patthoff, LCSW
2/7/07	.	[illegible]
		[illegible]
		NO SE from ↑ in Effexor .
		[illegible]
		Mood [illegible]

Cont c Rx. [illegible signature]

HARRIS METHODIST H·E·B Hospital Texas Health Resources

2021

MULTIDISCIPLINARY PROGRESS NOTES
998540804 / NS-189 (3/03)
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PATIENT IDENTIFICATION
HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJAMI,HADI R
01/24/07 USB F 043 DOB 06/18/63

FG 22056 (09/05)

DATE	HOUR	EACH NOTE MUST BE IDENTIFIED BY DISCIPLINE NAME AND SIGNED BY LICENSED STAFF
1-24-07		Admit NSR.
		C.C. I'm scared. I had c panic attack
		Hx. Pt felt paralyzed after confrontation at work
		[illegible] [illegible] [illegible]
		Pt. was dc from IOP ē Jan.
		Was 1st seen in nov. 06.
		H/o anemia.
		Saw Susan B. yesterday.
		Not sleeping well.
		[illegible]
		[illegible] Bedford ē an apt. [illegible]
		Works at Fidelity [illegible].
		Mood is dysphoric. ØS-1. ØH/.
		ØAVH
		I. (1) 311
		(2) GAD.
		II -
		III -
		IV ~~[illegible]~~ [illegible]
		ē GAF. 45
		Plan. Add Klonopin 1 mg ⓟ PM #20
		[signature]

MULTIDISCIPLINARY PROGRESS NOTES
898540804 / NS-189 (3/03)
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HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

MRN: 60021237HEB Visit: 204004143003 D[illegible]pe: 2021 CONFIDENTIAL INFORMATION

DATE	HOUR	EACH NOTE MUST BE IDENTIFIED BY DISCIPLINE NAME AND SIGNED BY LICENSED STAFF
2/14/07		Feels good & focused
		ØSI ØHI
		No SE from meds
		Cont c̄ [illegible]
		d/c tomorrow.
		[signature]

HARRIS METHODIST
H·E·B Hospital
Texas Health Resources

MULTIDISCIPLINARY PROGRESS NOTES
998540804 / NS-189 (3/03)
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2021

PATIENT IDENTIFICATION
HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

FG 22056 (09/05)

DATE	HOUR	EACH NOTE MUST BE IDENTIFIED BY DISCIPLINE NAME AND SIGNED BY LICENSED STAFF

MULTIDISCIPLINARY PROGRESS NO

998540804 / NS-189 (3/03)
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HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 1-26-07 (Adult) Adolescent ___ CD (Psych) ___ Dual ___ Inpatient ___ Outpatient ___ PHP (IOP)

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/ poor-hrs of sleep ____, Appetite- good/ poor, Household functioning- good/ poor, Explain:	
Drug/Alcohol Use: Explain:	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled: Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	

Process Group: Topic _____ Patient issues: _____

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ____ Orientation	Initials ____ Community
Initials ____ Goal Setting	Initials ____ Home Group
Initials ____ Occupational Therapy	Initials ____ C.D. Process
Initials ____ Relapse Prevention	Initials ____ Nutrition
Initials ____ Stress Management	Initials ____ Spirituality
Initials ____ Medication Education	Initials ____ Other
Initials ____ Life Skills	Initials ____ Family Education
Initials ____ Physician Lecture	Initials ____ Intensive Program
Initials ____ Stretching	Initials ____ School
Initials ____ Leisure Time	Initials ____ Peer Review
Initials ____ Step Study	Initials ____ Group Counseling
Initials ____ Recreation Therapy	Initials ____ C.D. Education

Notes: Pt. absent due to illness.

CLINICIAN SIGNATURE	DATE/TIME	M Patthoff LCSW	1-26-07
		CLINICIAN SIGNATURE	DATE/TIME
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

HARRIS METHODIST SPRINGWOOD
INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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2021

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 1-24-07 (Adult / Adolescent) ___ CD (Psych / Dual) ___ Inpatient ___ (Outpatient) ___ PHP ___ IOP

	INITIALS
Mood: Anxious, (Depressed) Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/ (poor- hrs of sleep 2. Appetite- good/ (poor) Household functioning- good/ (poor. Explain:	
Drug/Alcohol Use: Explain: Denies use currently	
Mental Status: (Oriented, Alert,) Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional. Explain:	
Appearance: (Neat, Clean,) Dishevled; Careless, Inappropriate dress, Explain:	MP
Thoughts: (Appropriate) Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal. Explain:	
Affect: WNL, (Blunted) Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: (Participated, Did not participate, (Attentive,) Inattentive, Tardy, (Cooperative,) Uncooperative, Interactive, (Withdrawn, Attention-seeking, Disruptive, Impulsive, (Slow to join,) Passive aggressive, Sarcastic, Manipulative, (Quiet,) Agitated, Restless.	
Process Group: Topic Identifying feelings Patient issues: Pt. reports feeling depressed + hopeless. Focus + memory are good. Pt. had panic attacks. She has not eaten much in 4 days.	
Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)	
Initials ___ Orientation	
Initials MP Goal Setting Affirmations	
Initials ___ Occupational Therapy	
Initials ___ Relapse Prevention	
Initials ___ Stress Management	
Initials MP Medication Education (By RN)	MP
Initials ___ Life Skills	
Initials ___ Physician Lecture	
Initials ___ Stretching	
Initials ___ Leisure Time	
Initials ___ Step Study	
Initials ___ Recreation Therapy	
Initials ___ Community	
Initials ___ Home Group	
Initials ___ C.D. Process	
Initials ___ Nutrition	
Initials ___ Spirituality	
Initials ___ Other	
Initials ___ Family Education	
Initials ___ Intensive Program	
Initials ___ School	
Initials ___ Peer Review	
Initials ___ Group Counseling	
Initials ___ C.D. Education	

Notes: This is pt's first day in IOP. She reports her mood as a -4 on a scale of 0 to -4 to -4 being the worst depression. Anxiety is also high at a 4.

		M Patterson, LCSW 1-24-07	
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN SIGNATURE	DATE/TIME
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

MRN: 60021237HEB Visit: 204004143003 Doc Type: 2021 CONFIDENTIAL INFORMATION

Date 1-31-07 (Adult) Adolescent ___ CD ___ (Psych) ___ Inpatient ___ Dual ___ (Outpatient) ___ PHP ___ (IOP)

	INITIALS
Mood: Anxious, (Depressed), Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/(poor) hrs of sleep 4, Appetite- good/(poor) Household functioning- good/poor, Explain:	
Drug/Alcohol Use: Explain: Denies use currently.	
Mental Status: (Oriented), (Alert), Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	MP
Appearance: (Neat), (Clean), Disheveled; Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, (Suicidal), Homicidal, Explain: Passive SI. Pt. denies plan or intent to harm. Contracts for safety.	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, (Guarded), Other –	

	INITIALS
Behavior: (Participated), Did not participate, (Attentive), Inattentive, Tardy, (Cooperative), Uncooperative, (Interactive), Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	

Process Group: Topic: Identify feelings. Patient issues: Pt. continues to feel hopeless, [illegible] frustrated. Says she got upset & stressed at her insurance Co. She said, "I want to go to sleep & not wake up."

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ______ Orientation		Initials ______ Community		
Initials ______ Goal Setting		Initials ______ Home Group		
Initials ______ Occupational Therapy		Initials ______ C.D. Process		
Initials ______ Relapse Prevention		Initials ______ Nutrition		
Initials MP Stress Management (4). Coping.		Initials ______ Spirituality		MP
Initials MP Medication Education (By RN)		Initials ______ Other		
Initials ______ Life Skills		Initials ______ Family Education		
Initials ______ Physician Lecture		Initials ______ Intensive Program		
Initials ______ Stretching		Initials ______ School		
Initials ______ Leisure Time		Initials ______ Peer Review		
Initials ______ Step Study		Initials ______ Group Counseling		
Initials ______ Recreation Therapy		Initials ______ C.D. Education		

Notes: Pt. reports a mood of -3 on a scale of 0 to -4 c̄ -4 being most severe depression. Anxiety, irritability, & anger remain high at a 3.

______ CLINICIAN SIGNATURE ______ DATE/TIME M Pettway LCSW 1-31-07 CLINICIAN SIGNATURE DATE/TIME

______ CLINICIAN SIGNATURE ______ DATE/TIME ______ CLINICIAN/RN SIGNATURE ______ DATE/TIME

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INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 1-29-06 (Adult) Adolescent ___ CD ___ (Psych) ___ Inpatient ___ (Outpatient) ___ PHP ___ IOP ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/ poor-hrs of sleep ___. Appetite- good/ poor . Household functioning- good/ poor, Explain:	
Drug/Alcohol Use: Explain:	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled; Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	INITIALS

Process Group: Topic _____ Patient issues: _____

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ___ Orientation	Initials ___ Community
Initials ___ Goal Setting	Initials ___ Home Group
Initials ___ Occupational Therapy	Initials ___ C.D. Process
Initials ___ Relapse Prevention	Initials ___ Nutrition
Initials ___ Stress Management	Initials ___ Spirituality
Initials ___ Medication Education	Initials ___ Other
Initials ___ Life Skills	Initials ___ Family Education
Initials ___ Physician Lecture	Initials ___ Intensive Program
Initials ___ Stretching	Initials ___ School
Initials ___ Leisure Time	Initials ___ Peer Review
Initials ___ Step Study	Initials ___ Group Counseling
Initials ___ Recreation Therapy	Initials ___ C.D. Education

Notes: Pt absent

M Patthoff, LCSW 1-29-06

CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN SIGNATURE	DATE/TIME
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-5-07 (Adult) / Adolescent ___ CD ___ (Psych) ___ Inpatient ___ (Outpatient) ___ PHP ___ (IOP) ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/ poor-hrs of sleep ___, Appetite- good/ poor, Household functioning- good/ poor, Explain:	
Drug/Alcohol Use: Explain:	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled; Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	

Process Group: Topic _____ Patient issues: _____

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ___ Orientation	Initials ___ Community
Initials ___ Goal Setting	Initials ___ Home Group
Initials ___ Occupational Therapy	Initials ___ C.D. Process
Initials ___ Relapse Prevention	Initials ___ Nutrition
Initials ___ Stress Management	Initials ___ Spirituality
Initials ___ Medication Education	Initials ___ Other
Initials ___ Life Skills	Initials ___ Family Education
Initials ___ Physician Lecture	Initials ___ Intensive Program
Initials ___ Stretching	Initials ___ School
Initials ___ Leisure Time	Initials ___ Peer Review
Initials ___ Step Study	Initials ___ Group Counseling
Initials ___ Recreation Therapy	Initials ___ C.D. Education

Notes:

Pt absent today.

CLINICIAN SIGNATURE	DATE/TIME	M. Patterson, LCSW	2-5-07 DATE/TIME
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

HARRIS METHODIST SPRINGWOOD
INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W, OSW
204004143 003 MR# 60021237
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-2-07 Adult ___ CD ___ Psych ___ Inpatient ___ Outpatient ___ PHP ___ IOP
Adolescent ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good, poor- hrs of sleep 8, Appetite- good, poor Household functioning- good, poor, Explain:	
Drug/Alcohol Use: Explain: Denies use currently	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional. Explain:	
Appearance: Neat, Clean, Disheveled, Careless, Inappropriate dress, Explain:	MB
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	
Process Group: Topic Identifying feelings Patient issues: Pt says she has no appetite + is forcing herself to eat a little. She is irritable + angry at her life. Feels she overcame breast cancer + many now 3	MB
Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate) other things but feels weak.	
Initials ___ Orientation	
Initials KB Goal Setting Crisis Plan	KB
Initials ___ Occupational Therapy	
Initials ___ Relapse Prevention	
Initials ___ Stress Management	
Initials ___ Medication Education	
Initials MP Life Skills Balance	
Initials ___ Physician Lecture	
Initials ___ Stretching	
Initials ___ Leisure Time	
Initials ___ Step Study	
Initials ___ Recreation Therapy	
Initials ___ Community	
Initials ___ Home Group	
Initials ___ C.D. Process	
Initials ___ Nutrition	
Initials ___ Spirituality	
Initials ___ Other	
Initials ___ Family Education	
Initials ___ Intensive Program	
Initials ___ School	
Initials ___ Peer Review	
Initials ___ Group Counseling	
Initials ___ C.D. Education	
Notes: Pt completed goal sheet and crisis plan —	KB

CLINICIAN SIGNATURE DATE/TIME — Kathy Beasley LPC 2-2-07 CLINICIAN SIGNATURE DATE/TIME

CLINICIAN SIGNATURE DATE/TIME — M Pollard, LCSW 2-2-07 CLINICIAN/RN SIGNATURE DATE/TIME

INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-9-07 Adult ___ CD ___ Psych ___ Inpatient ___ Outpatient ___ PHP ___ IOP
Adolescent ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/ poor-hrs of sleep ___, Appetite- good/ poor, Household functioning- good/ poor, Explain:	
Drug/Alcohol Use: Explain:	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled, Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	INITIALS
Process Group: Topic Identify feelings Patient issues: Pt feels her moods are more effective has her mood has been improving. Coping skills & everyday life tasks.	MJ

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ___	Orientation	Initials ___	Community
Initials KB	Goal Setting weekend plans	Initials ___	Home Group
Initials ___	Occupational Therapy	Initials ___	C.D. Process
Initials ___	Relapse Prevention	Initials ___	Nutrition
Initials ___	Stress Management	Initials ___	Spirituality
Initials ___	Medication Education	Initials ___	Other
Initials MJ	Life Skills Relapse Prevention	Initials ___	Family Education
Initials ___	Physician Lecture	Initials ___	Intensive Program
Initials ___	Stretching	Initials ___	School
Initials ___	Leisure Time	Initials ___	Peer Review
Initials ___	Step Study	Initials ___	Group Counseling
Initials ___	Recreation Therapy	Initials ___	C.D. Education

Notes: Pt set goal for the day and shared plans to take walk in the park near home. KB

		Kathy Beisly LPC 2-9-07	
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN SIGNATURE	DATE/TIME
		MJ Mabry RN 2-9-07	
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

HARRIS METHODIST SPRINGWOOD
INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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2021

HORTON,ELIZABETH,W.
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-7-07 Adult / Adolescent ___ CD ___ Psych ___ Inpatient ___ Dual ___ Outpatient ___ PHP ___ IOP

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep-good/poor-hrs of sleep ____, Appetite-good/poor, Household functioning-good/poor, Explain:	
Drug/Alcohol Use: Explain: Denies plan or usage.	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	MP
Appearance: Neat, Clean, Disheveled, Careless, Inappropriate dress, Explain:	
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	
Process Group: Topic: Identify feelings / Cognitive change. Patient issues: Pt. spoke about her divorce last June. Said it was the best thing she ever did even though everyone thought she was crazy divorcing an electrical engineer who made a lot of money.	MP

Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)

Initials ___	Orientation	Initials ___	Community
Initials MP	Goal Setting: affirmation	Initials ___	Home Group
Initials ✓	Occupational Therapy	Initials ___	C.D. Process
Initials ___	Relapse Prevention	Initials ___	Nutrition
Initials ___	Stress Management	Initials ___	Spirituality
Initials MP	Medication Education (By RN)	Initials ___	Other
Initials ✓	Life Skills	Initials ___	Family Education
Initials ___	Physician Lecture	Initials ___	Intensive Program
Initials ___	Stretching	Initials ___	School
Initials ___	Leisure Time	Initials ___	Peer Review
Initials ___	Step Study	Initials ___	Group Counseling
Initials ___	Recreation Therapy	Initials ___	C.D. Education

Notes: Pt. reports a mood of -2 on a scale of 0 to -4 c̄ -4 being the worst depression. Anxiety also remains a problem at a 2. Says she has a lot of fear about attempting to return to her job + facing a supervisor that tried to fire her. Began having her reframe that past painful event.

CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN SIGNATURE: Marilyn Pattoff LCSW	DATE/TIME: 2-7-07
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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(5/06)

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-14-07 (Adult) Adolescent ___ CD ___ (Psych) ___ Inpatient ___ (Outpatient) ___ PHP ___ IOP ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/poor-hrs of sleep ___, Appetite- good/ poor, Household functioning- good/ poor. Explain:	
Drug/Alcohol Use: Explain:	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled; Careless, Inappropriate dress, Explain:	MB
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal, Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	
Process Group: Topic Identify feelings Patient issues: Pt. stated she has been able to achieve abstinence & has goal issues & now looks forward to going on w. her life.	
Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)	
Initials ___ Orientation	
Initials MP Goal Setting Making Changes	
Initials ___ Occupational Therapy	
Initials ___ Relapse Prevention	
Initials ___ Stress Management	
Initials MP Medication Education (Buy RN)	MB
Initials ___ Life Skills	
Initials ___ Physician Lecture	
Initials ___ Stretching	
Initials ___ Leisure Time	
Initials ___ Step Study	
Initials ___ Recreation Therapy	
Initials ___ Community	
Initials ___ Home Group	
Initials ___ C.D. Process	
Initials ___ Nutrition	
Initials ___ Spirituality	
Initials ___ Other	
Initials ___ Family Education	
Initials ___ Intensive Program	
Initials ___ School	
Initials ___ Peer Review	
Initials ___ Group Counseling	
Initials ___ C.D. Education	
Notes:	

		M Bethroff LCSW 2-14-07	
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN SIGNATURE	DATE/TIME
CLINICIAN SIGNATURE	DATE/TIME	CLINICIAN/RN SIGNATURE	DATE/TIME

HARRIS METHODIST SPRINGWOOD
INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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(5/06)

2021

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Date 2-12-07 Adult ___ CD ___ Psych ___ Inpatient ___ Outpatient ___ PHP ___ IOP
Adolescent ___ Dual

	INITIALS
Mood: Anxious, Depressed, Labile, Hypomanic, Manic, Euthymic, Irritable	
ADL's: Sleep- good/poor-hrs of sleep 12, Appetite- good/ poor, Household functioning- good/ poor, Explain:	
Drug/Alcohol Use: Explain: denies use currently	
Mental Status: Oriented, Alert, Disoriented, Confused, Sleepy, Lethargic, Hallucinating, Delusional, Explain:	
Appearance: Neat, Clean, Disheveled; Careless, Inappropriate dress, Explain:	MP
Thoughts: Appropriate, Loose, Tangential, Preoccupied, Racing, Paranoid, Suicidal, Homicidal. Explain:	
Affect: WNL, Blunted, Flat, Labile, Anxious, Tearful, Exaggerated, Guarded, Other –	

	INITIALS
Behavior: Participated, Did not participate, Attentive, Inattentive, Tardy, Cooperative, Uncooperative, Interactive, Withdrawn, Attention-seeking, Disruptive, Impulsive, Slow to join, Passive aggressive, Sarcastic, Manipulative, Quiet, Agitated, Restless	
Process Group: Topic Identifying feelings. Patient issues: Pt. was able to share her feelings about movie "After the dance". Said, "It was the hardest thing I ever did."	
Patient Participated In Group Therapy/Counseling (circle and specify content as appropriate)	
Initials ___ Orientation ___ Initials ___ Community ___	
Initials KB Goal Setting Monthly Goals Initials ___ Home Group ___	
Initials ___ Occupational Therapy ___ Initials ___ C.D. Process ___	
Initials ___ Relapse Prevention ___ Initials ___ Nutrition ___	
Initials ___ Stress Management ___ Initials ___ Spirituality ___	
Initials ___ Medication Education ___ Initials ___ Other ___	
Initials MP Life Skills Problem Solving Initials ___ Family Education ___	MP
Initials ___ Physician Lecture ___ Initials ___ Intensive Program ___	
Initials ___ Stretching ___ Initials ___ School ___	
Initials ___ Leisure Time ___ Initials ___ Peer Review ___	
Initials ___ Step Study ___ Initials ___ Group Counseling ___	
Initials ___ Recreation Therapy ___ Initials ___ C.D. Education ___	
Notes: Pt completed goal sheet, reports taking a walk in the park over weekend, and was attentive to group discussion about traits that make for a healthy app	KB

CLINICIAN SIGNATURE DATE/TIME — Kathy Beasley LPC 2-12-07 CLINICIAN SIGNATURE DATE/TIME

CLINICIAN SIGNATURE DATE/TIME — MSHoff LCSW 2-12-07 CLINICIAN/RN SIGNATURE DATE/TIME

INTERDISCIPLINARY FLOW SHEET AND PROGRESS NOTES
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HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

MENTAL STATUS EXAMINATION

PATIENT: _____

GENERAL APPEARANCE:
Neat, Well Groomed, Careless, Dirty, Disheveled, Obese, Slim, Unshaven, Posture (stooped, stiff, bizarre).
Other: _____

ATTITUDE:
Appropriate, Dependent, Passive, Passive Aggressive, Manipulative, Cooperative, Resistive, Belligerent, Reserved, Seclusive, Negativistic, Sarcastic, Guarded. Other: _____

MOOD:
Euthymic, Anxious, Depressed, Hypomanic, Manic. Other: _____

AFFECT:
Appropriate, Labile, Blunted, Flat, Restricted. Other: _____

THOUGHT CONTENT:
Appropriate, Paranoid Trends, Hallucinations (auditory, visual), Delusions, Obsessions, Compulsions, Bizarre Thoughts, Suicidal Thoughts/Plans, Homicidal Thoughts/Plans.
Other: _____

THOUGHT PROCESS:
Logical, Tangential, Circumstantial, Goal-Directed, Loose, Slow, Confused, Incoherent, Preservation, Flight of Ideas.
Other: _____

MOTOR ACTIVITY:
Not remarkable, Hypoactive, Hyperactive, Tremulous, Tics, Ataxia, Paralysis.
Other: _____

ORIENTATION:
Time: (Yes, No) Place: (Yes, No) Person: (Yes, No) Situation: (Yes, No)

INTELLECT:
Intelligence: (normal, below normal, above normal)
General Information: (good, fair, poor)
Calculations: (good, fair, poor)
Remote Memory: (good, fair, poor) as demonstrated by: Recent presidents or personal dates/anniversary
Recent Memory: (good, fair, poor) as demonstrated by: Recall of 3 objects in 5 minutes
Immediate Recall: (good, fair, poor) as demonstrated by: Digitspan
Ability to Abstract: (good, fair, poor)

JUDGMENT: (good, fair, poor) as demonstrated by: Response to common sense questions.

INSIGHT: (good, fair, poor) as demonstrated by: Knowledge of reason for current level of care.

STRENGTHS: (List) _____

COMMENTS: _____

Physician/Clinician Signature and Date: _____ 1/24/07

PATIENT IDENTIFICATION

Harris Methodist Springwo

MENTAL STATUS EXAMINATION

FORM 998541069 (REV. 6/00)

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 DSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

2023

_____Admit to Psych Intensive Outpatient Program (IOP) and include patient in all routine group components of the Psych IOP Program

Patient is to participate in the following specialty groups:

_____Survivors of Sexual Abuse

_____Eating Disorder Individual Therapy Session

Complete the following for the patient:

_____Urine Drug Screen on admit and PRN

_____Breathalizer on admit and PRN

_____See attached orders for diagnosis and medications

☐ See attached orders for diagnosis and medications

Admitting physician, signature below, has prescribed the following psychotropic medications for this patient:

1. Effexor 150 1-24-07 4. _____
2. Klonopin 1-24-07 5. _____
3. _____ 6. _____

Patient's admitting DSM IV Diagnosis:

Axis I Major depression, Severe

Axis II —

Axis III —

Axis IV moderate

Axis V 45

Admitting Physician — Date and Time 1/24/07

RN or Clinician transcribing orders — Date and Time 1-24-07

HARRIS METHODIST SPRINGWOOD
Psych IOP Orders

1140 Physician Orders

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

ALLERGIES: Height _____ Weight _____

DATE: TIME: PLEASE PRESS HARD

☐ VERBAL TELEPHONE ORDER READ BACK / INITIAL _____

1/31/07

n Effexor XR 150 mg

1-31-07

1400

Signature: _____

Print Name: _____ FIRST LAST

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

DATE: TIME: PLEASE PRESS HARD

☐ VERBAL TELEPHONE ORDER READ BACK / INITIAL _____

Signature: _____

Print Name: _____ FIRST LAST

PATIENT IDENTIFICATION

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

1140

HARRIS METHODIST H·E·B Hospital
Texas Health Resources

PHYSICIAN ORDER
998540876 (REV. 9/06)
Page 1 of 1
CHART COPY

DO NOT USE ABBREVIATIONS

Q.D.	U	A.D.	Trailing Zero (X.0 mg)
Q.O.D.	S.C.	A.U.	Lack of Leading Zero (.X mg)
IU	S.Q.	O.S.	"Resume Home Meds"
MS	µg	O.D.	(includes Pre-op, procedure,
MSO4	X3d	O.U.	etc, medications)
MgSO4	A.S.		Chemotherapy Abbreviations

MRN: 60021237HEB Visit: 204004143003 Dc pe: 1140 CONFIDENTIAL INFORMATION

HARRIS ME DIST H-E-B Page 1 of 1
Discharge ription Form
DC

NEW DISCHARGE PRESCRIPTION FORM

Prescription given?	Medication	Strength	How much?	Route?	How Often?	Next Dose	Other Instructions
Y☐ NO☐ 1/31	Effexor XR	225	mg	po	daily		
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							
Y☐ NO☐							

Discharge Orders

Date/Time 2-14-07 Signature Juanita Johnson ID# ________

☒ Instructions and a copy of this form to Patient ☐ Information to next healthcare provider.

Please bring this medication record with you to your next physician office visit or on return to the hospital.

1140 Physician Orders

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

REV 12/15/2006 10:59

HARRIS METHODIST H-E-B
Home Medication Order Form
MEDRECON

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

1140

Unapproved Abbreviations

U, IU	S.C., S.Q.	Q.D., Q.O.D.	X3d	MS, MSO4, MgSO4	"Return ... mark"
A.S., A.D., A.U.	Chemotherapy abbreviations	O.S., O.D., O.U.	µg (for microgram)	Trailing zero or lack of leading zero	

ANY ORDER THAT CONTAINS ILLEGIBLE HANDWRITING OR UNAPPROVED ABBREVIATIONS WILL REQUIRE CLARIFICATION BY CONTACTING THE ORDERING PHYSICIAN

HOME MEDICATION ORDER FORM

Height _____inches Weight: _____kg (actual/stated)

Allergies and Reactions: ☒ NO KNOWN ALLERGIES

☐ NO HOME MEDS **LIST HOME MEDICATIONS BELOW** ☐ Pregnant ☐ Breastfeeding

LAY TERMS ONLY – Include over the counter meds, inhalers, eye drops

Continue In Hospital?	Medication (Herbals, nutraceuticals, vitamins, supplements should be documented but will not be continued in the hospital.)	Strength	How much?	Route	How Often?	Last Dose	Why take this medication?	Continue at home?	Next dose
YO NO	Effexor XR	150 mg	po	daily				YO NO	
YO NO	Lunesta	3 mg	po	HS				YO NO	
YO NO	Glyride	500/10	po	daily				YO NO	
YO NO	Lopid	10	po	daily				YO NO	
YO NO	Klonopin	1mg	po	QPM				YO NO	
YO NO								YO NO	
YO NO								YO NO	
YO NO								YO NO	
YO NO								YO NO	
YO NO								YO NO	
YO NO								YO NO	
YO NO								YO NO	

Source of Information: ☐ Patient ☐ Family ☐ Phys. Office ☐ H & P ☐ Pharmacy ☐ Med Bottles ☐ Unable to Obtain
☐ Other Chart Info. Obtained from: Pamela Sorrow
Signature:
*If above is not completed, contact admitting physician to review each item for a telephone order.
Date:

For Inpatient Use Only:
Reconciled Home Medications Admission Orders
Phys. Print Name ID#
Signature Date/Time
Noted by: Print Name ID#
Signature Date/Time

For Inpatient Use Only: Effexor 2 tabs
Reconciled Discharge Orders
Printed Name ID#
Signature
Date/Time

☒ Instructions and a copy of this form to Patient ☐ Information to next healthcare provider.

Record all new medications on the Discharge Prescription Form

REV 12/15/2006 10:52

Discharge patient from: ☐ Psychiatric Program ☐ CD Program

☐ Inpatient ☐ Intensive Outpatient Program ☐ PHP

Effective Discharge Date: 2/14/07

☐ See attached orders for diagnosis and medication

Discharge Diagnosis: (Include DSM IV TR frequency and severity digits)

Axis I 311, GAD

Axis II_____

Axis III_____

Axis IV_____

Axis V_____

Discharge Medications:

Effexor XR 225, Klonopin 1mg QHS

Ambien 37

Discharge Plan:

Patient is to follow-up with the following Springwood Program:

Partial Hospital Program ☐ Psychiatric ☐ CD

Intensive Outpatient Program ☐ Psychiatric ☐ CD ☐ Day

Program Start Date:_____

Patient is to follow-up with the following physician(s):

Attending Physician _____ Appointment Date_____

And/or

Patient's own Psychiatrist_____

Primary Care Physician_____

Medical Reason for PCP follow-up_____

Other Referrals_____

Signature Nurse [signature] Date 2-14-07

Signature Physician [signature] Date 2/14/07

HARRIS METHODIST SPRINGWOOD

DISCHARGE ORDERS

406

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Elizabeth Horton
F
2

CRISIS PLAN

1. When I feel suicidal and in crisis I will call:

A.	24-hour crisis/suicide line # 1-800-suicide
B.	My doctor/psychiatrist MENT Health - 817-658-7748
	Next appointment is:
C.	My therapist
	Next appointment is:
D.	A friend - Ross Park 817-658-2372
E.	Another friend Ross Park 1 c c
F.	Go to the emergency room/call 911 HEB -

1282

2. When I experience the symptoms associated with my illness, (hopelessness, anger, isolation, paranoia and/or BP)
I will:
   A. Call someone I trust and talk about what is going on.
   B. Write about my thoughts and feelings in my journal.
   C. Write a gratitude list: What gives me hope? What is a light at the end of the tunnel?
      1. hopelessness
      2. Isolation
      3. Bed
   D. Call my doctor or therapist.

3. I will join a support group: AA/NA, Co-dependents Anonymous, Depression Support Group. 817-335-5465
Name of Group

4. When I am over whelmed, these are reminders of ways to take care of myself:
   - ☑ BREATHE!!!!!! Take long, slow deep breaths.
   - ☑ Find a safe place (physically or visualizing a special place where you can go and get grounded, fell relaxed, protected, calm, centered, and at ease).
   - ☑ Go for a walk.
   - ☑ Take a hot bath.
   - ☑ Put a cool wash cloth on your forehead.
   - ☑ Try to sleep.
   - ☑ Pray.
   - ☑ Do a mundane chore - dishes/laundry/clean a drawer out.
   - ☐ Watch a movie.
   - ☐ Eat something yummy.
   - ☑ **Know that these feelings will pass and know that you are safe.**

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

5. **I AGREE WITH THIS PLAN AND WILL KEEP MYSELF SAFE.**
Signed: Elizabeth Horton Date: 2/7/07

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Harris Methodist Springwood
(To be completed by patient)

(3)

Name: Elizabeth Horton

Reason for Seeking Services: Suicide Thoughts. Can't sleep Panic Attacks

1.Do you need to go to the Emergency Room for any of the following: (Please Circle): Yes___ No✓

1. Significant Bleeding
2. Chest Pain
3. Significant Pain (please give a description of the pain)_____
4. Sudden Confusion
5. Significant Fever
6. Recent serious accident without medical attention

Have you recently been seen in an Emergency Room? If yes, when_____ Yes___ No✓

2. Have you had a recent overdose without seeking medical attention? If yes, when_____ Yes___ No✓

3. Are you having any thoughts today about hurting yourself or someone else? Yes___ No✓

4. Do you have a current plan for how you would hurt yourself or someone else? Yes___ No✓

5. Are you currently in any danger of being physically or sexually abused? Yes___ No✓

6. Are you having any of the following related to alcohol use? Yes___ No✓

Seizures____ Vomiting____ Diarrhea____

7. Do you believe you need to be detoxed from alcohol? Yes___ No✓

8. Are you using any other drugs?_____ Yes___ No✓

9. Is someone with you now? If yes, who is with you? Yes___ No✓
Mother____ Father____ Sibling____ Friend____
Spouse____ Employer____ EAP____

10.. Are you looking for:
Inpatient____ Medication Referral____
Outpatient✓ Community Resources___

Outpatient

1282

FAMILY OF ORIGIN HISTORY:

Where were you born? Marianna, Arkansas
Who were you raised by? Mother & father
If either of your biological parents was absent, why? NO

Describe your family when you were growing up? Close knit. lots of love.

Was there any family history of psychiatric problems? If so, who? NO

Was there any family history of alcohol or drug problems? If so, who? NO

IMMEDIATE FAMILY HISTORY:

What is your current marital status: (Circle)
Married, Separated, Divorced, Widowed, Single
If married, how long? ~~18 yrs~~ If separated/divorced/widowed, how long? 6 mos.
Were you previously married? (circle) No, Yes; If yes, complete:

Approximate years	Reason for breakup
4 years	no moral support

Do you have children: (circle) No, Yes:

Name	Age	If yes, complete: Where child resides:
Leverta Butler Jr.	24	Marianna, ARK 72360
Tanika Butler	22	Marianna, ARK 72360
Tanisha Butler	20	Marianna, ARK 72360

HARRIS METHODIST SPRINGWOOD
IOP PSYCHOSOCIAL ASSESSMENT

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

What is your ~~sexual orientation~~: (circle)
Heterosexual, Homosexual, Bisexual
Have there been any recent changes in your living arrangements? NO

Have there been any recent stressors in these areas? (circle)
Financial, Legal, Relationship, Family, Work/School
If so,explain: Manager being ~~[illegible]~~ inconsiderate with my mental condition, and placing pressure on me

Have there been any recent deaths or deaths of anyone significant to you in the past?
no

Describe your usual daily schedule: ~~[illegible]~~ NO energy
no hope - weak

EDUCATION & EMPLOYMENT HISTORY:

What is the highest level of education that you completed? 16
Describe any problems you had with grades or behavior in school? none
If you had college or vocational training, what area/subject was it in? Computer Programming
What is your current job? Customer Service
Who is your current employer? Fidelity Investments
How long have you been employed there? 6 Mos.
Do you plan to work while in treatment? no
Do you plan to return to work after treatment? yes
Are you in school at this time? Yes No If so, where?
If you are unemployed, how long since you were last employed?
Who was your previous employer?
If you are unemployed, what is your source of financial support?
How many jobs have you held in past 5 years? 3
Have you ever had any experiences of being fired or layed off? If so, describe the situation: no
Did you serve in the military? (circle) Yes; No
If so, what branch?
Did you have an honorable discharge? (circle) Yes; No
How many years did you serve?
Does your military experience have any impact on your current problems? (circle)Yes; No
If so, explain:

ALCOHOL/DRUG USE:

Please complete the following:

Substance	Last use	Current amount/freq	Greatest amount/freq	Way it was used	Age at first use
Alcohol	Never				
Marijuana	Never				
Amphetamine	Never				
Cocaine	None				
Heroin	Never				
Prescription Drugs	1/24/07				
Hallucinogens	None				
Inhalants	None				
Nicotine	Never				
Other					

What time of day and what days do you generally use alcohol and/or drugs? N/A

Do you think you have an alcohol or drug abuse or dependence? N/A

What is the longest period of time you have gone without any use of drugs or alcohol? N/A When was that? _____

Have you ever been preoccupied with the thought of using, especially when you are clean? Yes (No)

Have you ever used a large amount or used quickly when you first start to use? Yes (No)

Have you used more and more to get high? Yes (No)

Have you ever used to relax, calm down, or sleep? Yes (No)

Have you ever used alone or when no one else is using? Yes (No)

Have you ever not remembered what you did or said when using? Yes (No)

Have you ever kept a bottle or stash, just in case you run out? Yes (No)

Have you ever used alcohol or drugs when you tried not to use, especially when you knew it would be detrimental? Yes (No)

Have you experienced shakes or tremors in the morning? Yes (No)

Have you ever used in the morning to get yourself going? Yes (No)

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 · OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

Describe any problems in these areas related to your drug or alcohol use:

Legal: _____
Family: _____
Job related: N/A
Medical: _____
Other: _____

Does anyone in your home use alcohol or drugs? NO
Doe you socialize with anyone who uses alcohol or drugs? NO
Have you participated in any gambling activity? Yes (No) Explain: _____
Do you think you have or have had problems associated with gambling? Yes (No)
If so, explain _____
Have you ever participated in AA/NA? (Yes) No If so, when ? _____

SAFETY ISSUES

Have you ever experienced physical, sexual, or emotional abuse? (Yes) No (Circle)
If so, by whom and when? My ex-husband
Was anyone contacted about the abuse (such as police, CPS, a parent)? (Yes) No
Explain? He was arrested for an assault to my face
Have you ever abused someone physically, sexually, or emotionally? Yes (No) (Circle)
If so, who and when? _____
Was anyone contacted about the abuse (such as police, CPS, a parent)? Yes (No)
Explain? _____
Is there currently any domestic violence? NO

STRENGTHS & WEAKNESSES:

What do you value most? My life
What are your strengths? Going the extra mile to achieve goal
What are your limitations? Mental disorder
How do you feel about yourself today? worthless
What are your goals for your treatment? To believe that a Mental Illness don't mean you're not a good person
What barriers are there to these goals: none

PLAN & NEEDS FOR DISCHARGE:

Do you need any information on housing, food, or financial assistance? Yes (No)
Do you need any information about educational or legal assistance? (Yes) No
If you are on psychiatric medications, will you follow-up with the psychiatrist treating you here or with another psychiatrist? Yes

COUNSELOR - COORDINATION OF INFORMATION:

Review of Intake Assessment: (Yes) No Discharge planning sheet initiated: (Yes) No
Review of PSY Eval: (Yes) No Safety issues resolved: (Yes) No
Review of Outpatient Health Screen: (Yes) No

Primary Counselor _____ Date _____

Marilyn Pattloff LCSW 1-31-07

Social Worker Date-

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

IOP PSYCHOSOCIAL ASSESSMENT

PATIENT NAME Elizabeth Horton AGE 43 DATE 1-23-07
LOCATION OF ASSESSMENT HEB SPG REFERRAL SOURCE grev. pt.
PRESENTING PROBLEM/CHIEF COMPLAINT (QUOTE PATIENT): depression, panic attacks, brought on by work stress since Fri.
PRECIPITATING STRESSORS Work

DAILY FUNCTIONING

- ☒ INCREASE/DECREASE SLEEP NEED ☐ N/A
  4 HOURS PER NIGHT
- ☒ INCREASE/DECREASE APPETITE ☐ N/A
  _____ POUNDS LOST/GAINED
  IN WHAT TIME PERIOD _____
- ☐ BINGEING/PURGING ☒ N/A
- ☒ SOCIAL WITHDRAWAL ☐ N/A
- ☒ INCREASE/DECREASE ENERGY ☐ N/A
- ☒ INCREASE/DECREASE SEX DRIVE ☐ N/A
- ☒ INCREASE/DECREASE ACTIVITY LEVEL ☐ N/A
- ☒ INCREASE/DECREASE PERSONAL CARE/HYGIENE ☐ N/A
- ☒ DECREASE IN WORK/SCHOOL PERFORMANCE ☐ N/A
  - ☒ EMPLOYED
    EMPLOYER Fidelity Investment
  - ☐ RETIRED
  - ☐ UNEMPLOYED; HOW LONG _____
  - ☐ DISABLED
    TYPE _____
- ☒ CHANGES IN MARRIAGE/PERSONAL RELATIONSHIPS ☐ N/A
  divorced since June
  SUPPORT FROM _____
  LIVES WITH: self
  LENGTH OF TIME YOU HAVE HAD SYMPTOMS since Nov.

DANGER ASSESSMENT

SUICIDAL IDEATION _____
☐ YES ☒ NO (IF YES, DESCRIBE)
SUICIDAL INTENT _____
☐ YES ☒ NO (IF YES, DESCRIBE)
SUICIDAL PLAN _____
☐ YES ☒ NO (IF YES, DESCRIBE)
WHAT DOES PATIENT LOOK FORWARD TO feeling better
PREVIOUS ATTEMPT took 7 Lunesta on Friday to sleep
☐ YES ☒ NO (IF YES, DESCRIBE)
HOMICIDAL/IDEATION/INTENT/PLAN _____
☐ YES ☒ NO (IF YES, DESCRIBE)
HISTORY OF VIOLENCE/HOMICIDE _____
☐ YES ☒ NO IF YES, WHAT TYPE ☐ PHYSICAL ☐ SEXUAL
DIRECTED TOWARDS ☐ PERSON ☐ PROPERTY ☐ OTHER, DESCRIBE _____
SOURCE OF INFORMATION ☐ PATIENT ☐ FAMILY ☐ POLICE ☐ OTHER _____
SELF-MUTILATIVE BEHAVIOR _____
☐ YES ☒ NO (IF YES, DESCRIBE)
HISTORY OF ABUSE physical from spousal
☒ YES ☐ NO (IF YES, DESCRIBE)
IS SOMEONE HARMING YOU CURRENTLY? ☐ YES ☒ NO (IF YES, DESCRIBE) _____
ACCESS TO WEAPONS OR CACHE OF MEDICATIONS _____
☐ YES ☒ NO (IF YES, DESCRIBE) IF YES, DOES PATIENT AGREE TO HAVE THESE REMOVED ☐ YES ☐ NO
CONFIRMED BY (NAME) _____
FAMILY HISTORY OF SUICIDE, ASSAULT, OR HOMICIDE _____
☐ YES ☒ NO (IF YES, DESCRIBE)
FAMILY HISTORY OF MENTAL HEALTH PROBLEMS _____
☐ YES ☒ NO (IF YES, DESCRIBE)
PREVIOUS PSYCHIATRIC HOSPITALIZATION DATE _____ PLACE NA RESULT _____
☐ YES ☒ NO TOTAL # 0 DATE _____ PLACE _____ RESULT _____
PREVIOUS/CURRENT OUTPATIENT PSYCHIATRIC TREATMENT
DATE Dec 06 TYPE/NAME IOP Springwood RESULTS _____
DATE _____ TYPE/NAME _____ RESULTS _____
PREVIOUS PSYCHIATRIC MEDICATIONS NONE
PRESCRIBED BY WHOM _____
CURRENT PSYCHIATRIST DR. Tajani

HOSPITAL BOX MUST BE CHECKED

Texas Health Resources

Patient Identification

ADULT PSYCHIATRIC AND CHEMICAL DEPENDENCY
SCREENING & REFERRAL FORM

9985490836 (12/06) Page 1 of 3

☐ HMHEB ☐ HMSW ☐ HMNW ☐ HMFW ☐ HMSPG

HORTON,ELIZABETH,W,
204004143 003 MRN 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

9025

SUBSTANCE ABUSE HISTORY

SUBSTANCES	LAST USED (TIME /DATE & AMOUNT)	ROUTE	USUAL AMOUNT/FREQUENCY	AGE OF FIRST USE
NICOTINE	NA			
ALCOHOL				
MARIJUANA				
AMPHETAMINES				
COCAINE				
HEROIN				
PRESCRIPTION DRUGS				
HALLUCINOGENS				
INHALANTS				
OTHER				

DEPENDENCY/SYMPTOMS

CURRENT	PAST	
☐	☐	BLACKOUTS
☐	☐	FAMILY PROBLEMS
☐	☐	LEGAL PROBLEMS
☐	☐	WORK PROBLEMS
☐	☐	FINANCIAL PROBLEMS
☐	☐	AM USE
☐	☐	LOSS OF CONTROL
☐ NA	☐	IMPAIRED MEMORY
☐	☐	SLEEP DISTURBANCE
☐	☐	INCREASED TOLERANCE
☐	☐	PREOCCUPATION
☐	☐	USING TO RELAX, CALM DOWN, SLEEP
☐	☐	OTHERS UPSET/ANGRY WITH YOUR USE
☐	☐	HAVE YOU TRIED TO QUIT USING AND FAILED
☐	☐	FELT GUILTY OR DEPRESSED AFTER USE

WITHDRAWAL SYMPTOMS

CURRENT	PAST	
☐	☐	SEIZURES
☐	☐	SWEATS
☐	☐	CRAMPS
☐	☐	AGGRESSION/ASSAULT
☐	☐	TREMORS
☐	☐	NAUSEA
☐	☐	TINGLING/NUMBNESS
☐ NA	☐	DELIRIUM TREMENS/HALLUCINATIONS
☐	☐	DEPRESSION
☐	☐	TACHYCARDIA
☐	☐	AGITATION
☐	☐	FEVER/CHILLS
☐	☐	INCREASED BLOOD PRESSURE

FAMILY HISTORY OF ALCOHOL/DRUG PROBLEMS ☐ YES ☒NO

PREVIOUS CD TREATMENT DATE _____ PLACE NONE HOW LONG SOBER _____

DATE _____ PLACE _____ HOW LONG SOBER _____

LONGEST PERIOD OF SOBRIETY: LENGTH _____ DATE _____

VITAL SIGNS: _____ TIME _____ BP ↑ _____ BP ↓ _____ PULSE _____ RESPIRATION _____ BAL

HOSPITAL BOX MUST BE CHECKED

Texas Health Resources

Patient Identification

ADULT PSYCHIATRIC AND CHEMICAL DEPENDENCY SCREENING & REFERRAL FORM

998540836 (12/06) Page 2 of 3

☐ HMHEB ☐ HMSW ☐ HMNW ☐ HMFW ☐ HMSPG

9025

HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63

APPEARANCE
- ☐ WELL GROOMED
- ☒ APPROPRIATE ATTIRE
- ☐ POOR HYGIENE
- ☐ CLOTHING DISHEVELED/DIRTY

BEHAVIOR
- ☐ PSYCHOMOTOR AGITATION
- ☐ PSYCHOMOTOR RETARDATION
- ☐ TREMOR
- ☐ INVOLUNTARY MOVEMENTS
- ☒ WNL

SPEECH
- ☐ SPEECH COHERENT
- ☐ NORMAL QUALITY & QUANTITY
- ☐ HYPERVERBAL
- ☒ PRESSURED
- ☐ SLOWED

AFFECT
- ☐ WNL
- ☒ BLUNTED/FLAT
- ☐ INAPPROPRIATE TO CONTENT
- ☐ LABILE
- ☐ EXAGGERATED

COOPERATION
- ☒ GOOD
- ☐ POOR
- ☐ GUARDED
- ☐ VARIABLE

MOOD
- ☒ ANXIOUS
- ☐ ANGRY/HOSTILE
- ☒ DEPRESSED/SAD
- ☐ LABILE
- ☐ IRRITABLE
- ☐ ANHEDONIA/HOPELESS
- ☐ EUPHORIC/ELATED
- ☐ EUTHYMIC

INTELLECT
- ☐ ABOVE AVERAGE
- ☒ AVERAGE
- ☐ BELOW AVERAGE
- ☐ UNABLE TO ASSESS

MEMORY
- ☐ WNL
- ☒ RECENT MEMORY DEFICITS
- ☒ REMOTE MEMORY DEFICITS

ORIENTATION
- ☒ TIME
- ☒ DAY
- ☒ DATE
- ☒ PLACE
- ☒ PERSON

GENERAL COMPREHENSION
- ☐ GOOD
- ☒ FAIR
- ☐ POOR

JUDGMENT
- ☐ GOOD
- ☒ FAIR
- ☐ POOR

INSIGHT
- ☐ GOOD
- ☒ FAIR
- ☐ POOR

SENSORIUM
- ☒ ALERT
- ☐ LETHARGIC
- ☐ CLOUDED

THOUGHT CONTENT
- ☒ LOGICAL/COHERENT THOUGHT PROCESSES
- ☐ DELUSIONS SPECIFY _____
- ☐ LOOSE/TANGENTIAL
- ☐ RACING THOUGHTS
- ☐ SLOWED THOUGHTS
- ☐ OBSESSIONS/COMPULSIONS

PERCEPTIONS denies
- ☒ AUDITORY HALLUCINATIONS
- ☒ VISUAL HALLUCINATIONS
- ☒ DEPERSONALIZATION

PATIENT HISTORY REVIEWED INCLUDING MEDICATIONS ☒ YES ☐ NO

SUMMARY: 43 y/o divorced black female presents with depressed mood & panic disorder. She denies thoughts of suicide or homicide currently. She reports difficulty sleeping, decreased appetite, energy, activity, & personal hygiene. She denies any substance abuse.

PHYSICIAN DIAGNOSIS AND RECOMMENDATIONS

PHYSICIAN CONTACTED Dr. Tajani - Dr. Fisher

AXIS I MDD, panic disorder w/o Agoraphobia

AXIS II deferred

AXIS III hypertension, anemia

AXIS IV (STRESSORS) ☐ FINANCIAL ☐ LEGAL ☐ RELATIONSHIP ☐ FAMILY ☒ WORK-RELATED

AXIS V CURRENT 40 PAST ____

TREATMENT RECOMMENDATIONS Ψ IOP

RELEASE OF INFORMATION OBTAINED

☐ PRIMARY CARE PHYSICIAN OR OTHER TREATING PHYSICIAN NOTIFIED ☐ EMPLOYEE ASSISTANCE PROGRAM NOTIFIED ☐ THERAPIST NOTIFIED ☐ CASE MANAGER NOTIFIED ☐ OTHER RECEIVING RESOURCES NOTIFIED (DESCRIBE) _____

IF PATIENT DECLINES INPATIENT TREATMENT

☐ YES ☐ NO DOES PHYSICIAN BELIEVE PATIENT MEETS CRITERIA FOR INVOLUNTARY HOLD
IF YES, POLICE WARRANTLESS DETENTION REQUESTED ☐ YES ☐ NO

☐ YES ☐ NO AMA FORM SIGNED BY PATIENT

☐ YES ☐ NO PATIENT AND FAMILY (IF FAMILY AVAILABLE & CONSENT OBTAINED) ADVISED ABOUT EMERGENCY PROCEDURES

FINAL DISPOSITION Patient agrees to start Ψ IOP 1-24-07

Report and/or copy of PASR Assessment given to (Circle): Inpatient Staff, Outpatient Staff, Emergency Department Staff or other: _____

INTERVIEWER (PRINT) PATRICK GIBSON DATE 1-23-07 TIME 3:30 p.m.

SIGNATURE Patrick Gibson LPC SUPERVISING MD Dr. Tajani Dr. Fisher

HOSPITAL BOX MUST BE CHECKED

Texas Health Resources

Patient Identification

ADULT PSYCHIATRIC AND CHEMICAL DEPENDENCY SCREENING & REFERRAL FORM

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☐ HMHEB ☐ HMSW ☐ HMNW
☐ HMFW ☐ HMSPG

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HORTON,ELIZABETH,W,
204004143 003 MR# 60021237 OSW
DR. TAJANI,HADI R
01/24/07 USB F 043 DOB 06/18/63